

Office Use Only

Date Received: _____ Required Landmarks _____

Required Measurements Supplied _____ Workorder Complete _____

Ship To Address: _____

PO # _____

Practitioner Name: _____ Phone Number: _____

Patient Name: _____

Left Right Height _____ Weight _____ Activity Level: 1 2 3 4 Sex: M F

Date Measured: _____ Date Required: _____ Age: _____

1. Procedure

- Test Socket
 - Clear/PETG
 - Orfitrans Stiff
- Definitive Socket

2. Design

- Endoskeletal
- Exoskeletal
- Socket Attachment**
 - None
 - Four Hole Plate
 - Pyramid
 - Other _____

3. Suspension

- None
- Supply Lock (Y / N)
 - Bulldog
 - Kiss
 - Fillauer 3S
- Expulsion Valve Type _____
 - Lynn BK
 - Elevated Type _____
- Supra-Condylar
- Supra-Condylar/Supra-Patella

4. Insert/Liner Material

- None
- Pelite - Distal Pad Y / N
- Thermoplastic - Specify Type
 - Final Thickness _____
 - MPE
 - Proflex with Silicone
 - Proflex without Silicone
 - Other _____

5. Socket and/or Frame Material

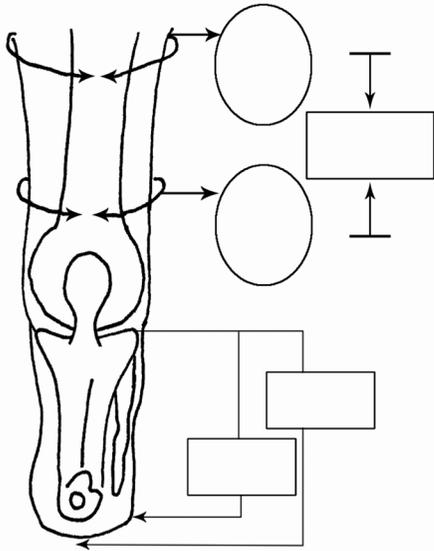
- AME/Epoxy
 - Layup**
 - Std.
 - Heavy Duty
 - Finish**
 - Carbon
 - Decorative Sleeve
 - PRS Color _____

6. Cover

- Yes
 - No Skin/Nylons
 - Spray Skin Y / N
 - Apply prefab skin (Y / N)
- No

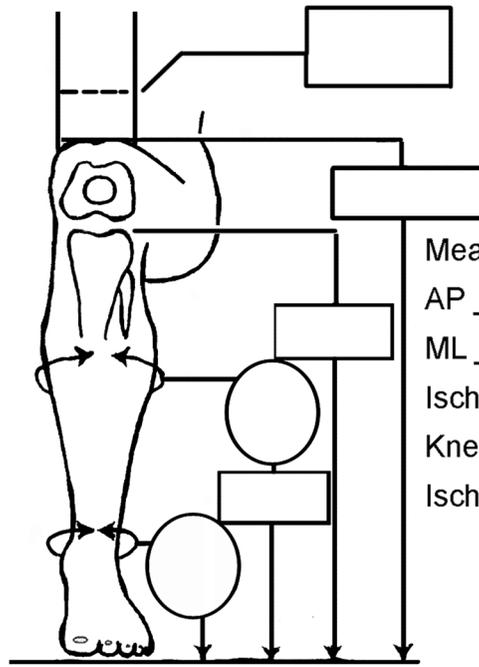
*** Our Guarantee...**
Requires work order, measurements and alignment lines. Accurate and complete data provided by you, shall enhance our mutual goal of "Total" Customer Satisfaction.

- 2
- 1
- MPT
- 1
- 2
- 3
- 4
- 5
- 6



A/P _____

M/L _____



Measurements:

AP _____

ML _____

Ischium to distal End _____

Knee center to floor _____

Ischium to floor _____

BILL TO:

Cascade Orthopedic Supply
2638 Aztec Drive • Chico, CA 95928

Notes/Comments/Parts to Order: _____

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